The DYLL REVIEW
We take the worry out of Peer Reviews
25 Highland Park Village #100-177 Dallas TX 75205
Phone: 888-950-4333 Fax: 888-9504-4443

Notice of Independent Review Decision

March 26, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Medical Necessity *COSA* Left Shoulder AC Joint & Glenohumeral Injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. The physician has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Upon independent review the physician finds that the previous adverse determination should be ~ Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

is a male with left shoulder pain, seen. He underwent an arthroscopic surgical repair of a rotator cuff tear in September of 2012. Unfortunately, he continues with ongoing left shoulder pain. Pain is reportedly aggravated with lifting. Physical examination findings have noted normal range of motion without evidence for atrophy. Rotator cuff stress tests are normal, and there is a negative impingement sign. Radiographs of the left shoulder showed both acromioclavicular as well as glenohumeral joint arthrosis.

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ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Upon independent review, I find the previous adverse determination should be upheld.

ODG guidelines are very specific as to the criteria for steroid injections in the shoulder. These would include a diagnosis of adhesive capsulitis, impingement syndrome, or other rotator cuff problems. None of these diagnoses is delineated in the medical records. The physical examination reports full and painless range of motion of the affected shoulder, and there is no reported abnormality for impingement testing. Additionally, information is lacking with regards to other conservative treatments, including physical therapy, exercise, and nonsteroidal anti-inflammatory medications for a period of up to three months.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☐ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**